PROTOCOL FOR THE PREVENTION OF ABUSE OF HEALTH CARE STAFF

Prepared by the Ministerial Committee on Abuse of Health Care Staff for the Ministers of Labour, Justice and Health

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EXECUTIVE SUMMARY

Protocol for the Prevention of Abuse of Health Care Staff

There have been serious concerns expressed about the growing number of incidents and severity of staff abuse in the health care workplace. This concern polarized in the fall of 1989 with alarming survey results from the Manitoba Association of Registered Nurses, along with serious concerns expressed in the brief "All in a Day's Work", from the Manitoba Nurses Union. In addition, other unions, registering bodies and health care facilities had previously spoken out on the issue of the prevention of staff abuse.

Under direction from the Ministers of Health, Labour and Justice, a committee for the prevention of staff abuse in the health care workplace was formed. The committee was fortunate to have knowledgeable members with a wide diversity of perspectives from government, unions, employee registering bodies and allied interest groups. This contributed substantially to the quality and comprehensiveness of the final report.

The mandate of the committee was to identify concerns surrounding abuse of health care staff and provide a broad outline for the development of essential guidelines and protocols at the facility level. The committee was to identify communication and education strategies along with recommendations on special situations involving staff abuse in health care. The committee has worked over a period of two years to develop this report and recommendations. They unanimously feel this report should be effective in assisting and providing direction to health care facilities, to reduce the risk of potential staff abuse.

Summary of Key Points

The governing board and administration must play a vital role in the recognition and follow-through to prevent staff abuse with appropriate policies, security and education programs.

The Workplace Safety and Health Committee must assume a greater role in making recommendations, monitoring and developing prevention strategies to reduce risk of staff abuse.

There must be a dedicated program in health care facilities for the prevention of staff abuse.

There must be a strong commitment at the facility level to educate all staff on recognition and intervention strategies. Particular emphasis should be given to high risk areas.

There is a strong need, on a provincial level to coordinate education and resources to assist facilities in staff abuse prevention programs.

There must be research into staff abuse prevention.

There must be post-abuse support systems to support workers who are victims of violence and/or abuse.

Government departments responsible for administering the law must be given direction and renewed commitment to assist workers who have become victims of abuse.

It should be noted that, based on feedback from respective constituents, the committee expressed concerns about lack of knowledge of the extent and seriousness of abuse in health care facilities on the part of administrators of law enforcement agencies and the judiciary.

Conclusion

This report, *Protocol on Prevention of Abuse of Health Care Staff*, was an effort by a diverse, committed group to effectively reduce the risk of staff abuse in health care facilities. There are already high expectations and enquiries surrounding this report from member organizations of the committee.

Ministerial Committee on
Abuse of Health Care Staff

RECOMMENDATIONS FOR THE MINISTERS

Based on the protocol, the Ministerial Committee on Abuse of Health Care Staff recommends the following:

Recommendation #1: That an abuse prevention program be developed and implemented in all health care facilities in Manitoba.

Recommendation #2: That any abuse prevention program developed include the following components:

- mission, philosophy and policies which outline the facility/organizations commitment to provide a safe work environment;
- risk management which addresses both the physical environment and the organizational climate;
- education of all health care staff, including board members and management; and
- follow-up which includes mechanisms for reporting and reviewing abusive incidents.

Recommendation #3: That special health care facilities, staffing and programs be available for those clients who abuse staff because of organic conditions.

Recommendation #4: That all health care facilities have a two-part educational program on the prevention and management of abusive situations: a core section which is taught to all employees and an area-specific section to provide additional education to staff who work in potentially dangerous areas or with clients known to be high risk. This program should be an integral part of the orientation program for new staff and it should be reviewed with all staff annually.

Recommendation #5: That the Health Care Sector Safety and Health Council develop and coordinate a core educational program in the management of abusive behaviour for use within health care facilities.

Recommendation #6: That Manitoba Health fund the development of a core educational program.

Recommendation #7: That health care facilities be provided with the necessary staff development funds to educate all staff on the prevention and management of abusive situations.

Recommendation #8: That educational programs for students of health care disciplines include training in the prevention and management of aggressive behaviour.

Recommendation #9: That the Health Care Sector Health and Safety Council develop a standard form for reporting incidents of abuse.

Recommendation #10: That health care facilities follow-up on all incidents of abuse and provide a post-abuse support program for staff.

Recommendation #11: That each health care facility ensure policies regarding "working alone" and the "right to refuse dangerous work" are compatible with provincial legislation.

Recommendation #12: That health care facilities, in conjuntion with local law enforcement agencies, develop a protocol for security procedures and responses in abuse situations.

Recommendation #13: That there be dialogue and the development of action plans by the Ministers and their departments which incorporate the recommendations of this report.

Recommendation #14: That the three Ministries develop a specific awareness campaign for the judiciary and the police on the seriousness and frequency of abuse in the workplace and the need to deal with it appropriately.

Recommendation #15: That a general public awareness campaign on the seriousness of health care abuse be implemented.

Recommendation #16: That Manitoba Health Information Network (M.H.I.N.E.T.) and other appropriate agencies establish a bibliography and a collection of information related to abuse of health care workers to facilitate wider dissemination and easier access to literature pertaining to abuse of health care staff.

Recommendation #17: That government, unions, employers, registering bodies and allied interest groups promote further research to examine the incidence and characteristics of abusive behaviour and the effectiveness of methods to deal with it.

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PROTOCOL FOR THE PREVENTION OF ABUSE OF HEALTH CARE WORKERS

1. Introduction

Abuse of health care staff is a growing and serious problem. Health care workers are demanding that programs and systems be put in place to reduce incidents of abuse and to deal with the aftermath of abuse. Health care administrators recognize the problem and are attempting to address the need to create a safe work environment.

The issue is complicated in that abuse occurs in many forms - verbal, physical, emotional and sexual. Abuse may occur between health care workers, clients, visitors, medical practitioners, managers and co-workers. Regardless of the form of abuse and the parties involved, health care facilities need to become active in protecting health care workers from abuse. This requires commitment. Leadership for this commitment must come from the governing board of each facility/organization and be communicated through the senior management to all staff and the community.

The Ministerial Committee on Abuse of Health Care Staff was formed at the request of the Ministers of Health, Labour and Justice, in response to growing concern about this issue. Committee members included representatives from the Manitoba Government, health care facilities and organizations, health care unions and nurse registering bodies.

Mandate

The mandate of the committee was to:

1. Identify areas of concern of the parties represented with regard to abuse of staff in health care facilities/organizations.

2. Develop guidelines and protocols to assist health care facilities/organizations in developing comprehensive policies, procedures and programs to address abuse of staff.

3. Recommend to the Ministers a communication strategy for the implementation of programs to address abuse of staff.

4. Develop and recommend criteria for components of educational programs.

5. Identify and make recommendations to the Ministers regarding special situations that exist in health care.

Purpose

The purpose of this document is to provide guidelines for health care facilities/organizations to use in developing comprehensive policies, procedures and programs to address abuse of staff. Included is a list of recommendations to the Ministers for implementing abuse programs in health care facilities/organizations province-wide, considerations for improving public awareness and the need for information and data collection.

DEFINITIONS

The committee developed the following definitions to facilitate understanding of the content of these guidelines.

Staff Abuse: Refers to any expression of negative emotion directed toward a staff member(s) that hurts or causes harm through verbal, physical, sexual or psychological means. Abuse, assault and violence are terms used interchangeably in the literature to describe behaviors ranging from verbal abuse and emotional harm to criminal activities such as common assault (which includes wounding, maiming, disfiguring or endangering life).

Client: Includes patients, residents, others who receive care and services from health care workers.

Guideline: Directing principle.

Health Care Institutions:
Hospitals, personal care homes, community health centres, psychiatric institutions.

Ministers: Ministers of Labour, Health, and Justice

Other Health Care Settings:
Include community health, outreach programs, doctors' offices, home care, public health, Victorian Order of Nurses, private nursing agencies, clinics, residential care facilities.

Protocol: A set of guiding principles and practices.

Policy: Forms the written basis of operation, secondary to legislation and the organization's bylaws. Policies serve as guides for decision-making; they prescribe limits and pinpoint responsibilities within an organization. Policies can be viewed as rules...related to the facility's overall mission, goals, and objectives. They are usually broad statements that are general in content.(1)

Procedure Gives directions according to which daily operations are conducted within the framework of policies.(1)

(1) Source: Adopted from Cryderman, Paula. Developing Policy and Procedure Manuals. Canadian Hospital Association, 1987, p.10.

II. Roles And Responsibilities

Role of Governing Boards and Administration

It is incumbent on the board of directors and senior administration of all facilities/organizations to ensure that staff are provided with a safe and secure work environment and are protected from abusive behavior. Ensuring a safe environment is a multifaceted process and must involve staff participation from all levels and at each stage.

The board of directors/senior administration should:

* Acknowledge the potential risk of staff abuse in the health care setting.
* Recognize the negative impact that an incident of staff abuse may have on a facility.
* Develop comprehensive security measures and systems that prevent/reduce incidents of an abusive
* nature. Assess and review, on an ongoing basis, enhancements or modifications to the facility's
* security programs, and consider security issues during the design process when construction and renovations are being undertaken as part of this process.
* Ensure the implementation of a comprehensive and ongoing staff training program to assist staff in managing abusive behavior.
* Establish a system for reporting incidents of abuse which are reviewed from a security perspective to determine changes that should be implemented immediately to prevent or reduce the risk of recurrence.
* Communicate and liaise with community and local law enforcement agencies regarding issues concerning staff abuse and violence.

Role Of Workplace Safety And Health Committee

In compliance with Section 40 (7) (Appendix A) of *The Workplace Safety and Health Act* the safety and health committee will recommend to administration policies and procedures to address the abuse of health care workers. The committee should be instrumental in developing, promoting and evaluating the abuse prevention program. In order to ensure that the policies and procedure implemented are relevant to the facility's unique character, the committee should ensure that all occupational groups are included in the initiatives and activities.

Internal and/or external resources may be drawn upon in the development process. Internal resources may include nurses, social workers, physiotherapists, chaplains and security officers. External resources may include police and legal experts.

Role Of Health Care Workers

Health care workers have a pivotal role in ensuring the successful implementation of a program to address abuse of staff. This role encompasses:

* Treating co-workers, clients, and the public with respect and dignity
* Participating in the development and implementation of policies and procedures
* Participating in educational programs
* Reducing incidents of abuse by practising principles of abuse prevention
* Reporting incidents of abuse as outlined in facility/organizational procedures

III. Developing An Abuse Prog~am

The purpose of this section is to provide direction to a facility's board, senior administration and Workplace Safety and Health Committees regarding the development and implementation of an effective program to deal with staff abuse in the workplace. This program should include four components:

A. Mission, philosophy and policies which outline the facility/organization's commitment to provide a safe work environment

B. Risk Management which addresses both the physical environment and the organizational climate

C. Education of all health care workers, including board members and management staff

D. Follow-up which includes mechanisms for reporting and reviewing abusive incidents

The following will address each of these components in detail.

A. Mission, Philosophy And Policies

The facility/organization's mission statement should include a commitment to provide a safe work environment. This commitment must be supported by a philosophy that recognize the value and contribution of all health care employees, and the belief that the facility bears a responsibility for creating an attitude of mutual respect among and between health care workers and the recipients of their services.

In keeping with the mission statement and philosophy, the board and administration should develop policies which make it clear to staff, clients, visitors, volunteers, physicians and all who access the facility, that abusive behavior will not be tolerated. The first step in developing policy is adopting a definition of abuse. This provides a common point of reference for all staff.

The policy should also recognize the need for an assessment of risks. This assessment should be conducted jointly by administration and staff, and take into consideration all aspects of a safe work environment. (See appendix B).

The policy should support the development and implementation of an educational program, including attendance requirements for staff.

Administration support for staff who are abused should be identified, including support for employees who choose to lay legal charges.

Lastly, the policy should identify reporting systems and review mechanisms to monitor the effectiveness of the facility's program to reduce risk and severity of abuse.

B. Risk Management

Prevention/reduction of incidents of abuse is a major component of a comprehensive abuse program. The facility must create an environment that discourages abusive behaviour. This is challenging. Clients, visitors and other staff may demonstrate inappropriate behaviour that staff may be unprepared to handle. The facility's physical plant may not be adequately secure to enable staff to care for aggressive clients in safety. This is even more challenging to facilities dealing with persons who have been admitted as involuntary patients due to danger to self and/or others.

Kroll and MacKenzie (1983) point out that "if a unit is committed to an open door policy, or is architecturally designed to be comfortable and homey rather than secure, or its staffing pattern is not designed to contain assaultive patients, then the unit should not admit patients at high risk for suicide or assault. It is the hospital's responsibility, within the bounds of human error and capability, not to offer psychiatric care to disturbed patients whom it is not equipped or staffed to treat safely." This responsibility is subject to the requirements of the law.

Physical Environment

The board and senior administration have a responsibility to ensure the facility is adequately secure to protect staff from abusive behaviour.

Areas which should be taken into consideration when assessing the physical plant for staff safety include:

- access control
- staff entrances located in well-lit, highly visible areas
- appropriate alarm systems installed on all strategic entrances/exits
- one way fire doors located at strategic exits
- clear signage for direction and traffic flow for visitors and clients

Windows

- windows are secured from the interior of the building

Alarm Systems

- appropriate alarm systems strategically located in areas where there is effective monitoring and response
- personal alarms similar to pagers provided to "at risk" staff

Parking lots

- staff parking lots located in well-lit, central locations and where possible, security monitoring of parking lots.
- where possible, security personnel assigned to accompany night staff to cars

Lighting

- well-lit building interior corridors and tunnels
- light fixtures which automatically respond to sound or movement installed in strategic locations on building exteriors

Organizational Climate

The board and administration have a responsibility to provide safe, quality client care, but they also have a responsibility to respect staff and provide a safe work environment. Considerations in this area are:

Staffing

There are times within a health care facility when health care workers may be placed in a working alone situation. Other groups such as home care workers, Victorian Order of Nurses, and public health nurses would consistently be placed in working alone situations. Both employers and workers should be familiar with Manitoba Regulation 105/88R Respecting Workers Working Alone (copy attached as Appendix C). This regulation, which is made under *The Workplace Safety and Health Act*, has an accompanying Code of Practice which explains the key concepts and outlines a process to develop a "working alone plan" to suit the specific circumstances of a particular situation.

If extra staff are required to manage an aggressive patient, careful assessment must be made with respect to the type of staff required. At times, an extra security guard may be required. On the other hand, if the client's aggressive behaviour occurs as the result of social isolation, provision of a volunteer to stay with the client may be all that is necessary.

Community Workers

Community health care workers who must visit clients in their homes, should not enter a dangerous situation by themselves. Often it may not be the client who is considered dangerous, but the client's surroundings. Requests for the accompaniment of a partner, ie. another health care worker or a police officer, should be supported by administration.

Administration should support a community worker's decision not to enter a situation deemed to be unsafe.

Communication

When an abusive incident is anticipated, staff must be able to call for assistance. Often, when a patient must be subdued, staff who work in other areas of the facility, may be required to assist. An emergency code, such as "Code 0", should be established to ensure prompt response of team members to episodes of abuse. A system should be developed whereby specific persons on every shift respond to a "Code 0" call.

A telephone "Code-word" should be established that could be used in a telephone conversation that would alert the receiver, but not the client, that the caller is in trouble. Other communication devices, eg. electronic silent alarm systems, may be necessary in specific situations.

Staff from all areas of the facility should be educated on the communication plan for the workplace setting.

Local Law Enforcement

The police should be involved in developing security procedures and responses. This includes determining the level of response that can be expected from the police during an incident.

C. Education

The facility's administration should ensure that all health care workers receive training and continuing education in appropriate approaches to managing abusive behaviour (Section 4, *The Workplace Safety and Health Act).* The value of this education has been shown to be enhanced by strong administrative support and by review on an annual basis. In addition, managers should ensure that staff know their job functions, authority and responsibilities in responding to incidents of abuse and reporting such incidents (Section 5, *The Workplace Safety and Health Act).*

The educational program should be comprised of two parts: a core section which is taught to all employees and an area-specific section to provide additional education to staff who work in potentially dangerous areas or with clients known to be high risk. The focus and depth of the two part program will be determined by the current knowledge base of staff, their contact with clients in the work setting and types of clients served by the organization.

Target Groups

Board members: an orientation to the risk of abuse to health care workers and the need for appropriate security and protective measures.

All staff: part one of the educational program which defines abuse; discusses ways to prevent, reduce and intervene in abusive situations; and explains policies and procedures related to abuse.

New staff: orientation to the facility program and training in techniques for management of abusive behaviors.

Staff in high risk areas: more frequent inservices focused on specific techniques suitable for the types of behaviors manifested.

Components of the Staff Education Program

The following components should be included in the staff education program.

Manifestations of Abuse

The educational program should:

- Include discussion of the many forms of abuse (verbal, physical, sexual) that may pose a threat to an individual or group of employees.

- Teach preventative measures and support systems available to deal with abusive behaviour.

- Emphasize individual differences in perception when defining an abusive situation. For example, a verbal threat may be received as non-abusive to some, but may impose serious mental distress upon others. These differences must be acknowledged.

- Identify that clients, clients' families, visitors, other members of the health care team may be sources of abuse. Assessing the potential for abusive behaviour in anyone is difficult and literature suggests it is even more difficult for psychiatric clients. Several high-risk factors have been identified, including a history of violence, a verbal threat of violence, male gender, age 15-30 years, and a history of substance abuse. An assessment tool based on these factors might assist in the determination of potential for violence (see Appendix D).

Prevention Strategies

The staff education program should:

- include a review of healthy human behaviour and behavioral disorders with reference to an organizational standard for behaviour which deems abuse by staff, clients or the public to be unacceptable. Research strongly suggests that lack of understanding of healthy human behaviour and behavioral disorders contributes significantly to occurrences of abuse.

- include discussion and identification of risk factors for those groups of clients known to demonstrate a greater tendency toward abusive behaviour or violence. A detailed presentation of causes, symptoms and problems associated with behaviour disorders should centre on those found in the staff's work setting.

- incorporate strategies for preventing an abusive situation from occurring.

Intervention Strategies

The program should include strategies for regaining control in an abusive situation. Some techniques to use are:

- verbal intervention skills—Violent episodes may be prevented before they escalate by using appropriate verbal skills. Discussion should occur on managing the stages of verbal escalation.

- physical intervention techniques—Basic principles of personal safety and practical application of actual techniques should be taught for situations where verbal interventions are ineffective. Wherever possible, a team approach should be used.

Plan To Manage An Aggressive Client

The education program should include a discussion on developing a plan to manage an aggressive client. Points to be considered are:

- assessing the person who is at risk or has a history of aggressive behaviour

- involving an interdisciplinary team to develop a comprehensive aggressive behaviour management plan individualized for the client

- availability and utilization, as appropriate, of environmental, physical and chemical restraints (Note: This is subject to the requirements of the law and of any applicable legislation including *The Mental Health Act of Manitoba, Charter of Human Rights* and the *Workplace Safety and Health Act.)*

- assigning and rotating experienced and trained staff

- orientating all new and casual staff to the plan

- documentation requirements and interdisciplinary team follow up every 24 hours.

Facility/Organization's Policies And Procedures

The education program should include:

- discussion of the facility's policies and procedures regarding abusive behaviour

- discussion of each staff member's responsibilities and each work area's responsibilities in managing and preventing abuse

- discussion of appropriate methods of reporting incidents of abuse. Such notification should be in verbal and written form. All health care workers should be aware of which supervisor to report to and which forms to complete

Legal Facts And Issues

Staff education concerning the legal facts and issues about the abuse of health care workers is essential. Areas that should be included as part of the overall educational program include:

Legal Definitions
- an over view of the justice system eg. civil vs. criminal law

- common terms and definitions relevant to the issue such as abuse, assault, harassment, etc.

Workplace Safety and Health Legislation
- rights and responsibilities of employees and employers
- the right to refuse dangerous work

Legal Actions
- legal rights of clients
- options available to staff in the event an abusive situation occurs
- clarification of ethical and legal considerations
- options available to the facility in the event an abusive situation occurs.

Legal obligations of a facility
the board and administration of the facility need to know their legal rights and obligations relating to abuse of staff.

Educational Resources

Initiatives should be undertaken to build a body of knowledge concerning approaches to preventing/reducing abuse of health care workers and to share this information and existing expertise among individuals and groups.

Several agencies have conducted literature reviews related to abuse of health care workers:

Manitoba Association of Registered Nurses
Ministers' Committee on Abuse of Health Care Workers
Unions representing health care workers
Individual facilities and agencies
Manitoba Labour Education Centre

This duplication of effort is an inefficient use of resources in terms of money, time and materials. In order to assist facilities to provide effective resource material and education a provincial program should be developed. This program would help facilities provide resources such as training manuals, information booklets, resource kits, educational videos, and other training methods to their staff.

D. FOLLOW UP

Documentation and reporting

Literature indicates that the incidence of client assault of health care workers is probably under-reported for some of the following reasons:

* lack of staff on the unit to take time to report especially if no injury has occured

* self-blame on the part of the victim

* fear of a negative response from peers and administration

* lack of staff education and training

* lack of policy directive

Administrative encouragement and requirements for documentation give a clear message that assault is not the fault of the victim.

There should be a general incident report form and/or a specially-designed form for reporting of an abusive incident (See Appendices E and F for examples of forms). It is desirable to have a standard abusive incident reporting form. The following information should be included in this report:

- type of abuse
- source of abuse
- client condition (where applicable
- precipitating factors
- description of incident
- description of injury sustained
- medical findings

The staff member who has been involved in an abusive occurrence should complete the incident form in as much detail as possible and submit it to his/her immediate supervisor. The supervisor should review the incident and document actions taken as well as any recommendations to prevent recurrence. The completed form should be submitted to the supervisor's department head, who should prepare a report for senior management and/or the Workplace Safety and Health Committee.

A summary report of abusive incidents should be part of the regular report to the health facility board and the facility's Workplace Safety and Health Committee. Sources of information for the summary report are: incident reports, sick leave reports, Workers' Compensation reports/claims, specialized reports such as security, police or maintenance department, and facility policy. Both the committee and senior management are responsible for evaluating incidents of abuse and recommending remedial action.

Post Abuse Support

The main objective of *The Workplace Safety and Health Act* is the promotion and maintenance of the highest degree of physical, mental and social well-being of workers. Therefore facilities should provide post abuse support services to health care workers who have been victims of violence on the job. The following initiatives are examples of post abuse service that could be available:

* prompt access to medical services and/or employee assistance programs in the event of injury
* alternative work following an incident (protective reassignment)
* medically prescribed mental health leave without loss of pay, benefit, or seniority
* notification by the employer to the alleged abuser or his/her family regarding potential legal charges
* review of the legal rights of the victim
* supporting the victim's right to make a complaint to the police
* employer assistance in processing Workers' Compensation claims
* immediately following the incident discussion in which all staff involved ventilate perceptions and feelings
* development of a plan to prevent recurrence

Both the immediate and 48-hour post incident reviews are essential for management to become aware of the needs of their staff following an abusive incident. A written report on the post-incident should be sent to the facility's Workplace Safety and Health Committee and to senior management.

IV.Research

Research should be encouraged. This should include the ongoing study of:

* the incidence and characteristics of abusive behaviour
* the effectiveness of methods of dealing with abusive behaviour, and
* patterns of abusive behaviour in health care settings

Several groups such as government, employers, nurse registering bodies and labour organizations may be able to assist with research design.

APPENDIX A

THE WORKPLACE SAFETY & HEALTH ACT (CSSMW210)

Duties of committee.

40(7) The duties of the committee include

(a) the receipt, consideration and disposition of concerns and complaints respecting the safety and health of the workers;

(b) participation in the identification of risks to the safety or health of workers or other persons, arising out of or in connection with activities in the workplace;

(c) the development and promotion of measures to protect the safety, health and welfare of persons in the workplace, and checking the effectiveness of such measures;

(d) co-operation with the occupational health service, if such a service has been established within the workplace;

(e) co-operation with a safety and health officer who is exercising his duties under this Act;

(f) the development and promotion of programs for education and information concerning safety and health in the workplace;

(g) the maintenance of records in connection with the receipt and disposition of concerns and complaints and the attendance to other matters relating to the duties of the committee; and

(h) such other duties as may be specified in this Act or regulations.

APPENDIX B

The following may be used as a guide in analyzing the risks to a facility and its staff and identifying security needs.

FRAMEWORK FOR ANALYSIS OF SECURITY RISKS/NEEDS

Institutional goals, functions, and operations
Institutional organization
People-oriented security priorities
The institutional setting: the geographic setting, image considerations, and limitations
The threat
The vulnerabilities to the threat
Total risk assessment
Evaluation of existing security and safety

Source: Turner James T., editor (1984). Violence in the Medical Care Setting. Rockville, Maryland: Aspen Systems Corporation.

MANITOBA REGULATION 105/88 R

Being a Regulation under
THE WORKPLACE SAFETY AND HEALTH ACT

Respecting Workers Working Alone

OFFICE CONSOLIDATION

NOTICE

All persons making use of this consolidation are reminded that it has no legislative sanction; that the amendments have been embodied only for convenience of reference; and that the original Act should be consulted for all purposes of interpreting and applying the law

THE WORKPLACE SAFETY AND HEALTH ACT
(C.C.S.M. c. W210)

Workers Working Alone Regulation

Regulation 105/88 R
Filed January 29, 1988

Definition

1 In this regulation, "working alone" means the performance of any work function by a worker who

(a) is the only worker for that employer at that workplace at any time, and

(b) is not directly supervised by his or her employer, or another person designated as a supervisor by his or her employer, at any time.

Securing workers from risks

2 Where a worker is working alone under circumstances which may result in injury, health impairment, victimization through criminal violence or other adverse conditions, the employer shall provide and implement a plan as a means of ensuring, so far as is reasonably practicable, the safety, health and welfare of that worker from risks arising out of, or in connection with, activities in that workplace.

Development of plan*

3 For the purpose of section 2, the employer shall consult and co-operate with the workplace safety and health committee, where such a committee exists, or with the worker safety and health representative, where such a representative has been designated, and with the worker who may be working alone, to

(a) assess the conditions or circumstances under which the worker is required to work alone; and

(b) develop and document a plan respecting the methods to be taken to ensure, so far as is reasonably practicable, the safety, health and welfare of the worker at that workplace, including a means of providing emergency assistance.

*The plan referred to in this regulation may be developed by utilizing information contained in "The Code of Practice for Workers Working Alone" which has been approved by the Director of the Workplace Safety and Health Division and published in the Manitoba Gazette.

Plan criteria

4 The plan developed in accordance with section 3 shall include, but not be limited to, the following information:

(a) name, address and location of the workplace;

(b) nature of the business;

(c) identification of possible risks to each worker who may be working alone;

(d) control methods developed to minimize each identified risk;

(e) details of the plan to provide a means of securing assistance for a worker working alone in the event of injury or other circumstance which may endanger the health or safety of the worker.

Plan agreement

5 Where the plan developed in accordance with section 3 has been mutually agreed upon,

(a) the plan shall be signed by both the employer and each worker who is required to work alone; and

(b) the employer shall give a signed copy of the plan to each worker who is required to work alone, and to that worker's supervisor.

Plan not agreed upon

6 Where the plan developed in accordance with section 3 cannot be mutually agreed upon, the employer, the worker, or both may notify a safety and health officer, and an investigation into the matter shall be undertaken in accordance with the principles outlined in subsections 43(6) to (8) of the Act.

Plan to be available to a safety and health officer

7 Where a plan has been developed in accordance with sections 3, 4, and 5, the employer shall maintain at the workplace a current signed copy of the plan, and the plan shall be made available to a safety and health officer upon request.

Adherance to plan

8 Where a plan has been mutually agreed upon in accordance with section 5, the employer and the worker shall comply with the plan.

Exemption

9 Where the Lieutenant Governor in Council has adopted another regulation which is in effect and has established work procedures for a worker working alone, this regulation does not apply.

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CODE OF PRACTICE
FOR
WORKERS WORKING ALONE

I. INTRODUCTION

This Code of Practice provides practical guidance concerning the requirements of Manitoba Regulation 105/88R, respecting "Workers Working Alone", adopted under The Workplace Safety and Health Act. It does not replace either the Regulation itself or the Act.

II. GENERAL INFORMATION

This Code of Practice is not intended to document the many and varied circumstances in which a worker may be required to work alone, or to specify a method of monitoring required for each specific working alone situation.

A significant number of job functions have been and will continue to be performed by workers working alone. Recognition of this fact indicates that those individuals involved must approach the hazards inherent to those occupations and develop safe work procedures.

The key concepts contained in the Regulation for Workers Working Alone are:

- The necessity of assessing all working alone situations to determine the conditions or circumstances which may result in misfortune to the workers working alone and attempt to reduce the probability of such misfortune; and
- The provision of a means of securing assistance for workers working alone in the event of injury or other misfortune.

III. THE WORKPLACE SAFETY AND HEALTH ACT

The next few sections present selected extracts from The Workplace Safety and Health Act which concern duties of employers and workers at work.

General Duties of Employers

4(1) Every employer shall in accordance with the objects and purposes of this Act

(a) ensure, as far as is reasonably practicable, the safety, health and welfare at work of all his workers; and

(b) comply with this Act and regulations.

Further duties of employer

4(2) Without limiting the generality of an employer's duty under subsection (1), every employer shall

(a) provide and maintain a workplace, necessary equipment, systems and tools that are safe and without risks to health, so far as is reasonably practicable;

(b) provide to all his workers such information, instruction, training, supervision and facilities to ensure, so far as is reasonably practicable, the safety, health and welfare at work of all his workers;
(c) ensure that all his workers, and particularly his supervisors, foremen, changehands or similar persons, are acquainted with any safety or health hazards which may be encountered by the workers in the course of their service, and that workers are familiar with the use of all devices or equipment provided for their protection;
(d) conduct his undertaking in such a way as to ensure, so far as is reasonably practicable, that persons who are not in his service are not exposed to risks to their safety or health arising out of, or in connection with activities in his workplace;
(e) consult and co-operate with the workplace safety and health committee where such a committee exists, regarding the duties and matters with which that committee is charged under this Act;
(f) consult and co-operate with the worker safety and health representative where such a representative has been designated, regarding the duties and matters with which that representative is charged under this Act;
(g) co-operate with any other person exercising a duty imposed by this Act, or the regulations.

General duties of workers

5 Every worker while at work shall, in accordance with the objects and purposes of this Act,
(a) take reasonable care to protect his safety and health and the safety and health of other persons who may be affected by his acts or omissions at work;
(b) at all times, when the nature of his work requires, use all devices and wear all articles of clothing and personal protective equipment designated and provided for his protection by his employer, or required to be used and worn by him by the regulations;
(c) consult and co-operate with the workplace safety and health committee, where such a committee exists, regarding the duties and matters with which the committee is charged under this Act;
(d) consult and co-operate with the worker safety and health representative, where such a representative has been designated, regarding the duties and matters with which that representative is charged under this Act;
(e) comply with this Act and the regulations, and;
(f) co-operate with any other person exercising a duty imposed by this Act or the regulations.

These are only a few of the items in the Act. The entire Act and relevant regulations should be studied in detail in order to gain working knowledge of their provisions.

IV. DEFINITION

The definition of "workers working alone" has been written in such a manner as to indicate that the regulation will apply to virtually all workers who are performing a job function and are not in the presence of their employer, another person in a supervisory capacity designated by the same employer, or another worker directly associated with the same employer, at the particular workplace location and during the same time period the working alone job function is being performed.

A great number of workers will fall into this category. However, during this time they may be in contact with workers associated with a different employer or the general public. Such contact does not eliminate the concept that the worker is working alone, and therefore, will require the same particular attention as outlined in the Regulation. Such instances may become an integral part of assessing the risks to which the worker may be exposed and the development of methods to secure assistance should misfortune occur, during the subsequent consultative process and plan development.

V. SECURING WORKERS FROM RISKS

As previously mentioned, subsection 4(2), clause (b) of The Workplace Safety and Health Act states that every employer shall "provide to all his workers such information, instruction, training, supervision and facilities to ensure, so far as is reasonably practicable, the safety, health and welfare at work of all his workers".

When workers are involved in working alone situations, consideration should be given to the fact that, should some misfortune occur, the worker may not be able to secure assistance as readily as when working with a group of co-workers.

With the understanding that misfortunes to workers will never be totally eliminated while performing any given job function, whether it be determined as working alone or not, both employers and workers have the responsibilities and duties to undertake that job function in the most knowledgeable and safest manner, thus minimizing the possibility of such misfortune.

An example of situations that utilize risk-reduction policy and procedures are those involving criminal victimization. The City of Winnipeg Police Department and rural constabulary detachments have developed an extensive program respecting Business Crime Prevention. Materials and information are disseminated upon request through their respective Community Relations sections.

VI. DEVELOPMENT OF PLAN

The Workplace Safety and Health Act requires a significant number of workplaces in the Province of Manitoba to establish a workplace safety and health committee or a worker safety and health representative. For further information, refer to the Act, Manitoba Regulation 106/88R and the Code of Practice for Safety and Health Committees.

The Workplace Safety and Health Act requires that employers and workers consult and co-operate with workplace safety and health committees or with the worker safety and health representative on matters regarding the safety, health and welfare at work of all workers at the workplace.

Safety and health committees and worker safety and health representatives should enhance the ability of workers and employers to resolve safety and health concerns reasonably and co-operatively. They should do so on their own, with a minimum of government involvement.

In workplaces where safety and health committees exist or where worker safety and health representatives are designated and have participated in the consultation procedure for plan development and agreement for workers working alone, it should be considered as having been a legitimate safety and health concern discussed, resolved and, therefore, be referenced in committee meeting minutes, submitted to the Workplace Safety and Health Division as indicated in the appropriate Code. The first and foremost condition that must always be considered is that a worker is working alone.

A. Assessment

When assessing the conditions or circumstances under which the worker is required to work alone, particular job functions will have inherent hazards associated with them that may be deemed as high risk, low risk or combinations of both. The degree of risk involved will not eliminate the requirement of developing control methods to minimize these risks.

Some examples of work functions that present high risk hazards may include:

- Entering any confined space
- Working with:
  - high energy materials (radioactive, high temperature)
  - toxic gases, liquids, or solids
  - cryogenic (low temperature) materials/processes
  - high pressure systems
  - high voltage electrical systems
  - moving equipment or machinery
- Working in:
  - extreme weather conditions
  - laboratory functions
  - services industries where job functions may not be hazardous but where cash or goods handled may cause the situation to attract criminal victimization
- Handling or transferring flammable liquids.

Some examples of work functions that present low risk may include:

- maintenance functions other than on active processing equipment
- security watchman's functions (except in hazardous locations)
- janitorial or custodial functions (except in hazardous locations)
- routine job functions that are part of a longstanding operating procedure and where experience has shown them to be safe
- desk work

B. Control Measures and Documentation

Upon assessing the conditions or circumstances under which a worker is required to work alone, control methods shall be developed and documented to minimize the identified risks arising out of or in connection with that activity. A means of securing assistance for the worker working alone in the event of injury or other misfortune shall be included.

The following suggestions may be incorporated as part of the developed plan. Dependent on the situations to which they are to be applied, the examples could constitute control methods to minimize risks, means of securing emergency assistance or a combination of both.

Checking the workers' well-being while working alone:

1) Second Person or "Buddy System"
The most appropriate work activity for the "buddy system" as part of a working alone plan is where workers are required to enter confined spaces.

"Confined spaces" mean areas in which access or egress is restricted, such as manholes, sleeves, pits, valve chambers or lift stations, and there is a danger of accumulation of hazardous gases, vapours, mists or lack of oxygen.

The Workplace Safety and Health Division regulates all confined entry work activities by requiring the use of the second person or "buddy system" as the **only** permissible control method and emergency assistance provision for the worker conducting the job function.

Such situations are referred to in Manitoba Regulation 189/85 [sections 112 and 142 and subsection 164(2)] and are outlined in Guidelines for Confined Entry Work.

The Division also requires compliance with Canadian Standards Association Standard W117.2-1974, entitled "Code for Safety in Welding and Cutting (Requirements for Welding Operators)":

9.4.5 Where a welder must enter a confined space through a manhole or other small opening, means shall be provided for quickly removing him in case of emergency. When safety belts and life-lines are used for this purpose they shall be so attached to the welder's body that his body cannot be jammed in a small exit opening. An attendant with a preplanned rescue procedure shall be stationed outside to observe the welder at all times and be capable of putting rescue operations into effect.

In all "buddy system" situations, consideration must be given to the buddy's qualifications. The buddy must be knowledgeable concerning the activities of the worker he/she is observing, be properly equipped with emergency equipment, and be capable of putting preplanned rescue or emergency operations into effect.

With the "buddy system", a second person's presence is required at all times. However, where the probability of serious consequence is high, both should not be exposed to the hazard simultaneously. The second person should be within sight, but safely removed from the immediate area.

2) Personal Check by Another Person

In many working alone instances, checking the worker's well-being may be achieved by periodic visits at regular intervals by an individual, such as the employer, another worker of the employer or someone designated by the employer.

The length of time between checks will depend on the estimated hazard of the job function.

As indicated in the "buddy system", the person designated to check the worker working alone must be knowledgeable of that worker's activities and must be capable of putting preplanned emergency operations into effect. Contact with the general public, such as, "passers by" is not considered adequate.

3) • Periodic Telephone Contact

Use of the telephone for communication at regular intervals may be adequate in low-risk working alone situations. Telephone numbers for routine calling and emergency situations would have to be posted prominently.

An example could include a night watchman's function at a location which has been determined to have low risk. Watchmen or security guards could call in to their dispatch offices at regular intervals, e.g., every hour prior to commencing their rounds, indicating their personal status at the workplace and the status of the workplace itself.

The intervals between these contacts would have to be determined by the estimated hazards at the workplace. Regulating the telephone contacts to specific times during that work function would reduce the number of false-alarm situations arising from the person working alone or contact person not being available for contact due to other than emergency situations.

Protection of persons involved in routine job functions will change when that person and job function are performed in non-routine conditions. These conditions include the absence of other workers in the workplace or when the function is being conducted during other than normal working hours for that person. Even for low-hazard activities, such as office desk work, that person should be instructed in and be knowledgeable about emergency procedures for working alone, for example, outside of regular office hours.

4) Constant or Intermittent Mechanical or Electronic Surveillance

When considering the use of mechanical or electrical surveillance equipment to accommodate the working alone situation, security systems in use at the workplace may be modified so that they will monitor a particular worker who is working alone as well as the status of the workplace itself.

Many workplaces utilize personal pagers, two-way radios, emergency sounding devices, visual monitoring systems, and similar equipment. This equipment is used as part of everyday operations. For reasons inherent to each particular operation, either wireless or hard-wired systems have been adopted.

The most important point to consider is the suitability of safety measures and systems to workers' needs. For example, if an employee is deaf, visible alarms should be provided in the workplace.

5) Central Monitoring

The development of protection and assistance plans for workers working alone, or the workplace in general, may include an arrangement whereby the activities of those required to work alone are monitored by a person or facility designated for that purpose.

When using a central monitoring system to relay an alarm, the following requirements must be addressed:

a) All federal, provincial and municipal regulations and by-laws must be met.

b) The system must be self-monitoring, with line security between the property and the station to ensure that the system is in operating condition at all times and that a compromised line will automatically signal the monitoring agency.

c) There must be an emergency power supply meeting applicable federal, provincial or municipal requirements to ensure the system is in operating condition at all times.

d) In rural areas, signal-to-station may be via auto or digital dialer.

VII. PLAN CRITERIA

Those persons directly involved in the consultation process for developing plans for workers working alone should ensure that as much information as possible is included to inform and instruct both the worker who is working alone and the supervisor as to the set procedures for that particular job function.

The criteria outlined in section 4 of the Regulation indicates the minimum information to be included in the plan.

Each specific type of activity will no doubt have particular requirements and procedures in place for the function to be conducted in the safest possible manner. These requirements may be a result of company policy or pertinent regulations or standards.

Working alone plans should be an extension of the safety and protective equipment necessary to perform that job function under any circumstance.

Instances may occur where a particular employer will have more than one employee working alone. Frequent staff turnover may also be a factor in operations involving working alone situations. Uniform plans could therefore be developed by the same process as previously described to cover these persons, if all persons directly involved in these working alone situations are in agreement. These types of "blanket plans" would be suitable only if the working alone situations involved similar conditions. Modifications would be necessary should a particular employee in a general plan have special needs.

Uniform plans should stipulate a fixed period for the plan to remain effective. At the end of such a time period, the plan should be reviewed and updated in the same manner as the original plan.

VIII. PLAN AGREEMENT

The signing of a plan that has been developed in accordance with section 3 of the Regulation will be an indicator of success in meeting this requirement of the Regulation.

The developed plan shall provide instruction for supervisors and workers and designate their respective responsibilities. The working alone plan shall be in writing and shall be provided to all workers and supervisors directly involved in the working alone environment.

IX. PLAN NOT AGREED UPON

Should a situation arise where the employer and worker, in consultation with the workplace safety and health committee or worker safety and health representative, cannot agree on an appropriate working alone plan, a safety and health officer and, at the option of the worker, another person representing the worker from that workplace may be requested to meet with those persons directly involved in the working alone environment to assist in resolving the matter.

In the event that agreement cannot be achieved on a plan, the appeal process will follow the system set forth in subsections 43(6) to 43(8) of the Act.

X. PLAN TO BE AVAILABLE TO A SAFETY AND HEALTH OFFICER

For the purpose of enforcing The Workplace Safety and Health Act and this Regulation, a safety and health officer may, at any reasonable time or where in his/her opinion a situation exists that is or may be dangerous, require any documents, books or records that relate in any way to the safety and health of workers to be produced for inspection and to make copies thereof or take extracts therefrom.

The employer shall maintain a current signed copy of the plan at the workplace.

XI. ADHERENCE TO DEVELOPED PLAN

As previously mentioned in Part III of this Code of Practice, The Workplace Safety and Health Act requires the employer to provide for the safety, health and welfare at work of all his or her workers, and workers are required to utilize provisions made for their protection while at work.

Workplaces are compelled to comply with Manitoba Regulation 105/88R (Workers Working Alone) unless exempted in section 9.

XII. EXEMPTION

The Workplace Safety and Health Division recognizes the fact that other Manitoba Government jurisdictions may develop legislation which will address requirements pertinent to their specific workplaces. This legislation will be developed in accordance with the specific objects and purposes of The Workplace Safety and Health Act.

For example, The Employment Standards Act has provisions regarding the employment of a child or adolescent which prohibit, restrict, or regulate their employment in workplaces deemed to be dangerous, unwholesome or unhealthy. Such legislation is considered to be complementary to the provisions of Manitoba Regulation 105/88R.

CODE OF PRACTICE

FOR

WORKERS WORKING ALONE

"I hereby approve this Code of Practice, the effective date of the approval being the 17th day of June, 1989

RON GLASSFORD, P.ENG.
Acting Director
Workplace Safety and Health Division

Dated at Winnipeg, Manitoba, this 2nd day of June, 1989

GLEN G. BLAHEY, CRSP
Witness
Commissioner for Oaths
Commission Expiry November 5th, 1990

Decision Table for Analysing the Likelihood of Violence or Aggressive Behaviour

1) Did admission symptoms relate to violence or threat of violence?
   If yes, go on to question 2. If no, stop here; this questionnaire is not relevant.

2) Does patient have a history of violent behaviour?
   If yes, check box and go on to question 3. If no, go on to question 4.

3) Does patient have a history of arrests or violence before age 15?
   If yes, check box; patient is already in very high risk group. Go on to question 4.

4) Have patient's admitting symptoms been adequately treated?
   If yes, go on to question 5. If no, stop here: patient cannot be released.

5) Is patient likely to stay on medication or other treatment?
   If yes, go on to question 6. If no, stop here: patient cannot be released.

6) Does patient have a paranoid disorder?
   If yes, check box; go on to question 7.

7) Does patient have below-average intelligence?
   IF yes, check a box for each yes. Go on to question 8.

8) Does patient have a pattern of alcohol or drug abuse?
   If yes, check box and go on to question 9. If no, go on to question 10.

9) Has patient's violence been related to alcohol or drug abuse?
   If yes, check box and go on to question 10. If no, go on to question 12.

10) Has patient identified a particular victim or, class of victims?
    If yes, check box and go on to question 11. If no, go on to question 12.

11) Will patient be likely to come into contact with identified victim?
    If yes, check box; go on to question 12.

12) Does patient have access to weapons?
    If yes, check box; go on to question 13.

13) Will patient return to the environment where violence originated?
    If yes, check box; go on to question 14.

14) Does patient have a stable environment to enter?
    If no, check box; go on to question 15.

15) Does patient have a job or training program upon discharge?
    If no, check box; go on to question 16.

16) Are patient's reasons for requesting pass or discharge reasonable?
If no, check box; go on to question 17.

17) Is there an adequate discharge treatment plan?
If no, check box.

Using the table

If answers to question 4 or 5 are no, patient cannot be discharged.
If a box for question 2,3,9, or 10 is checked, pass or discharge for patient is high risk.
If ten or more boxes are checked, pass or discharge is high risk.
If five to nine boxes are checked, none of which are for questions 2,3,9, or 10, there is some risk.

SOURCE: Kroll J. and T.B. MacKenzie (1983). "When Psychiatrists are Liable: Risk Management and Violent Patients." Hospital and Community Psychiatry. 34:1, (January) 29-36.

APPENDIX E

FORM A - CHARACTERISTICS OF THE AGGRESSIVE/ABUSIVE INCIDENT

Was an Incident Report completed? __ YES __ NO

Was a Workmen's Compensation Report completed? _ YES _ NO

A. Identifying data

1. Date: __/__/__/ (mo/da/yr) Unit: _____

2. Shift: ___ 12 hr ___ 8 hr ___ 4 hr

3. Day of week: ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ S

4. Place where behavior occurred (specify area): _____

5. Time incident began: _____ Duration of incident _____ (hours/minutes)

6. Persons involved: [ ] Nursing Personnel ___ male ___ female age ___
Status: _____

[ ] patient ___ male ___ female age: ___

Diagnosis _____

[ ] visitor - family [ ] ___ male ___ female
- friend [ ] ___ male ___ female
- other [ ] ___ male ___ female

[ ] hospital staff ___ male ___ female _____ status

[ ] physician ___ male ___ female

7. Incidents involving patients:

Patient Orientation

sedated [ ]

oriented [ ]

confused [ ]

language barrier [ ]dependent or bedfast [ ]

psychotic [ ]

other [ ] describe: _____

Level of Mobility

independent with or without aids [ ]

supervised [ ]

assisted with 1-2 people [ ]

8. Describe events preceding or precipitating the aggressive/abusive behavior:

_____

_____

_____

B. Aggressive behavior (check all that apply)

Verbal Aggression

__ makes loud noises, shout angrily
__ yells mild personal insults ("you're stupid")
__ makes moderate threats to others or self

__ makes clear threats of violence ("I'm going to kill you") or requests help to control self ("I'm going to kill her if you don't stop me")

Physical Aggression

__ makes threatening gesture, swings at people, grabs at clothes
__ strikes, kicks, pushes, pulls hair (without injury)
__ attacks others, causing mild-moderate physical injury (bruises, sprains, welts)

__ attacks others, causing severe physical injury (broken bones, deep lacerations, internal injury).

Physical Aggression Against Objects

__ slams door, scatters clothing, makes a mess
__ throws objects down, kicks furniture without breaking it, marks the wall
__ breaks objects, smashes windows, throws objects dangerously
__ sets fires

Indicate which behavior(s) occurred most frequently.

C. Intervention

Indicate which of the following interventions were used:

1. __ none
2. __ talking to individual
3. __ allowed individual to verbalize
4 __ diverted attention
5. __ closer observation (describe)
6. __ set limits (describe)
   _____
7. enforced limits
8. use of restraints (describe)

9. __ family called to sit with patient
10. __ 'sitter' arranged e.g. Medox, additional staff
11. __ immediate medication given by mouth
12. __ immediate medication given by injection
13. __ isolated from others
14. __ seclusion room
15. __ physical intervention by one person

16. __ code zero initiated
17. __ team intervention: physical ____
    verbal ____
    (describe) _____
18. __ supervisor notified
19. __ security notified
20. __ physician notified
21. __ other (describe)

Indicate (by using corresponding numbers) which of the above interventions were effective in dealing with the aggressive/ abusive behavior:

APPENDIX F

INCIDENT REPORT

RELATING TO ABUSIVE/AGGRESSIVE ACT(S) TOWARD HEALTH CARE PERSONNEL

SECTION I - IDENTIFYING DATA

NAME: _____ POSITION: _____

DATE OF INCIDENT: _____ TIME OF INCIDENT: _____

PLACE OF INCIDENT: _____ WARD (if applicable): _____

WITNESS(ES): _____

SECTION II

A) **TYPE OF ABUSE:** Verbal ☐ Physical ☐ Sexual ☐ Other ☐ Specify:

B) **INITIATED BY:** Patient ☐ Visitor ☐ Employee ☐ Other Health Professional ☐
Other ☐ Specify:

C) **PATIENT CONDITION:** (if caused by patient, complete the following) New Admission ☐
Violent ☐ Bed Patient ☐ Language Barrier ☐ Ambulant ☐ Hostile ☐
Disorientated ☐ Sedated ☐ Other ☐ Specify:

SECTION III - INCIDENT DESCRIPTION _____

_____

_____

_____

Person Reporting: _____ Date: _____

SECTION IV - INJURY INFORMATION:

Medical Attention: YES ☐ NO ☐ ; First Aid: YES ☐ NO ☐ ; Abusive
Language: YES ☐ NO ☐ ; Other: YES ☐ NO ☐ ; WCB Forms Completed: YES ☐ NO ☐
Loss/Damage to Personal Property: YES ☐ NO ☐ ; Specify: _____

_____

_____

_____

Medical Findings: _____

_____

_____

_____

_____ _____

Doctor's Signature Date

First copy to be submitted to Executive Director by Supervisor the same day as incident.

Second copy submitted to: _____ by _____
DON/Dept. Head Supervisor/Charge Nurse

Date: _____

First copy - White; Second Copy - Pink

SECTION V - **INVESTIGATION:** _____

_____

_____

_____

_____

- **PREVENTATIVE ACTION:** (Measures taken, planned or recommended): _____

_____

_____

_____

_____

_____

_____ _____

Signature & Title Date

SECTION VI - **FOLLOW-UP:**

	YES	NO	SPECIFY:
Time Away	☐	☐	_____
Counselling Made Available	☐	☐	_____
Advised of Legal Rights	☐	☐	_____
Initial Discussion/Review	☐	☐	_____
Comprehensive Incident Review	☐	☐	_____
Law Enforcement Involvement	☐	☐	_____
Nurse Personnel Interview	☐	☐	_____
W.P.S.& H. Committee Involvement	☐	☐	_____
Evaluation of Current Policies/ Procedures	☐	☐	_____

SIGNATURES:

_____ _____

DON/Department Head Date

_____ _____

Executive Director Date

POLICY

PURPOSE:

The purpose of an Incident Report is to provide management with specific information about how and why the incident occurred. Since the goal is to prevent further occurrences, it is essential that the Report be as complete as possible.

DEFINITION:

An incident is defined as any action or unusual occurrence which can have an adverse effect on staff.

POLICY:

An Incident Report form is completed following any unusual occurrence.

PROCEDURE:

The staff member who has been involved in an unusual occurrence completes the Incident Report form, in as great detail as possible, and submits it to their immediate supervisor.

The investigator reviews the incident and documents any recommendation(s) to prevent further occurrences.

The supervisor distributes the completed form to the Department Head/Director of Nursing and the Executive Director.

PM/lc March 17/92
1UU05/H:Rpts/Policy

INCIDENT REPORT INSTRUCTIONS

Any abusive/aggressive behaviour shall be reported on the Incident Report Relating to Abusive/Aggressive Act(s) Toward Health Care Personnel (refer to Policy #).

Forms can be initiated by the staff member who was involved in the incident or by another staff member who witnessed or discovered the incident.

SECTION I

Accurately enter your name, position, e.g., R.N., L.P.N., W.A., etc., place of incident, e.g., bathroom, activity, hallway, etc., date and time of incident, ward (if applicable); also include the name(s) of any person who witnessed the incident.

SECTION II

Check the appropriate box in A), B) and/or C) if the incident was caused by a patient. (In cases of sexual harassment, the appropriate collective agreement policies may apply).

SECTION III

Give a detailed and accurate description of the incident. Specify any pre-existing factors/conditions that led up to the incident.

Sign and date the Incident Form and forward to your immediate supervisor.

SECTION IV

Check the appropriate box(es) - if "Other", please specify. Indicate whether a W.C.B. form was completed (NOTE: a W.C.B. form should be completed in all instances).

If loss or damage of personal property was caused, please be specific as to what was lost or damaged.

If medical attention is required, whether for physical injury or mental injury, have an M.D. fill in the necessary information, including follow-up or further treatment if required. Make sure it is signed and dated.

SECTION V

An investigation into the cause of the incident should be described in detail by the person(s) designated according to facility policy.

Under preventative action, the investigator will describe the measures taken to prevent further incidents, the planned method of how to prevent further abuse and future prevention recommendations.

Have the investigator sign and date the form.

SECTION VI

The appropriate box(es) should be checked off. The responsibility for this section rests with the Director of Nursing/Department Head; Executive Director. Have them sign and date the form.